

**EXHIBIT F**

INFERTILITY INSURANCE SETTLEMENT  
C/O ATTICUS ADMINISTRATION  
PO BOX 64053  
SAINT PAUL MN 55164



<<claimantid>>\_<classcode>><<seqid>>

**Scan This  
Code to  
Complete  
Form  
Online:**

Display  
Category B or C  
QR Code Per  
Class Member  
Status

<<LITIGATION MEMBER NUMBER>>

Claimant ID: <<claimant ID>>

<<FIRST NAME>> <<LAST NAME>>

<<ADDRESS>>

<<CITY>> <<STATE>> <<ZIP>>

## CLAIM SUBMISSION FORM

*Goidel et al. v. Aetna Life Insurance Company*  
U.S. District Court, Southern District of New York  
Case No. 1:21-cv-07619 (VSB)

**CATEGORY C CLASS MEMBERS MUST COMPLETE AND RETURN  
THIS FORM SO IT IS RECEIVED BY BAR DATE TO BE ELIGIBLE  
FOR AN APPROXIMATE \$10,000 PAYMENT**

**COMPLETION AND SUBMISSION OF THIS FORM IS NOT GUARANTEE OF  
ELIGIBILITY. YOU MUST COMPLETE AND SUBMIT THIS FORM TO BE  
CONSIDERED.**

**PLEASE READ THIS CLAIM SUBMISSION FORM AND THE ENCLOSED  
SETTLEMENT NOTICE CAREFULLY**

### **ELIGIBILITY**

If you sought or could have sought coverage for one or more cycles of artificial insemination (intracervical insemination (“ICI”) or intrauterine insemination (“IUI)) (described below in Step 2) received between September 1, 2017, and May 31, 2024, you were in an Eligible LGBTQ+ Relationship as described in the Settlement Notice at the time, you have not requested exclusion from this settlement, and you complete and timely submit this form and the required Attestation Form, you may be entitled to an approximate \$10,000 payment, or a proportionally reduced payment if there are more than 200 class members. **Submission of this form is required if you’ve been identified as a potential Category C Class Member.**

### **GENERAL CLAIM SUBMISSION FORM INFORMATION**

Failure to comply with the instructions for completing a claim described on the next page may result in an ineligible claim. After you submit your claim, if additional information is required to complete your claim, you will be notified by mail and/or email. Any documents submitted as supporting evidence will not be returned. Please retain copies of your documents for your own records.

**Questions? Visit [www.InfertilityInsuranceSettlement.com](http://www.InfertilityInsuranceSettlement.com) or Call 1-800-205-6861**

**INSTRUCTIONS FOR COMPLETING A CLAIM**

BEFORE YOU BEGIN COMPLETING THIS FORM, contact the provider or providers you received artificial insemination from between September 1, 2017, and May 31, 2024, and request the following information that will be required to complete this Claim Submission Form.

I am participating in a class action settlement related to coverage for the provision of infertility services received between September 1, 2017 and May 31, 2024 and have been asked by my health insurer to provide the following information about the artificial insemination services I received from you during that time:

- (1) Provider Name
- (2) Provider Address
- (3) Provider TIN/PIN
- (4) National Provider Identifier (NPI)

For each service received during the relevant time period, please fill out the following:

CPT Code (check one):

\_\_\_ S4035 (Artificial Insemination; Menotropin)

\_\_\_ 58321 (Artificial Insemination; Intra-Cervical)

\_\_\_ 58322 (Artificial Insemination; Intra-Uterine)

Date of Service: \_\_\_\_\_

The amount billed to me for this service is: \$ \_\_\_\_\_

The amount I paid for this service is: \$ \_\_\_\_\_

You will also need the CPT Code(s) associated with the artificial insemination(s) you underwent. Descriptions of the applicable CPT Codes used for artificial insemination procedures covered by this settlement are as follows:

- (1) **S4035-Artificial Insemination Menotropin**  
Stimulated intrauterine insemination
- (2) **58321-Artificial Insemination; Intra-Cervical**  
In this procedure, the provider inserts prepared live sperm into the cervical canal.
- (3) **58322-Artificial Insemination; Intra-Uterine**  
In this procedure, the provider inserts prepared live sperm into the uterus through the cervical canal.

**Cycles of in-vitro insemination (“IVF”) will not qualify you for Class Membership and should not be submitted.**

In order to be considered for a payment, this Claim Form and the Attestation Form must be fully completed, signed under penalty of perjury, and received by the Settlement Administrator on or before Bar Date using one of the following methods:

ONLINE: [www.InfertilityInsuranceSettlement.com](http://www.InfertilityInsuranceSettlement.com)

MAIL: Infertility Insurance Settlement

c/o Atticus Administration

PO Box 64053

St. Paul MN 55164

EMAIL: [InfertilityInsuranceSettlement@atticusadmin.com](mailto:InfertilityInsuranceSettlement@atticusadmin.com)

FAX: 1-888-326-6411

### STEP 1: CLASS MEMBER INFORMATION

Class Member First Name

Class Member Last Name

M.I.

Aetna Member Number (W Number):

Social Security Number:

Employer/ Plan Sponsor:

Date of Birth (mm/dd/yyyy):

If the address on page one is correct check here:

If the address on page one is not correct, or if none is listed, provide info below:

Class Member Address

City

State

Zip Code

Class Member Email Address:

Class Member Telephone:

Pick One:

Mobile ☐

Home ☐

Are you acting on behalf of a deceased or incapacitated Class Member? NO ☐ YES ☐

*If you are acting on behalf of a deceased Class Member or a Class Member who does not have the capacity to act on their own behalf, documentation supporting your authority to act on their behalf will be required to validate your claim. To proceed, please complete the representative portion of the claim below and submit documentation substantiating your authority to act on behalf of the above Class Member.*

Questions? Visit [www.InfertilityInsuranceSettlement.com](http://www.InfertilityInsuranceSettlement.com) or Call 1-800-205-6861

**COMPLETE THIS PORTION OF STEP 1 ONLY IF YOU ARE ACTING ON BEHALF OF A CLASS MEMBER****Representative First Name****Representative Last Name****M.I.****Representative Address****City****State****Zip Code****Representative Email Address:****Representative Telephone:****Pick One:**Mobile ☐Home ☐**STEP 2: ARTIFICIAL INSEMINATION HISTORY**

Please provide the information in the following chart for each cycle of artificial insemination that you underwent between September 1, 2017, and May 31, 2024. Supporting evidence for each procedure you include is required and must be submitted with this form to verify your claim. Add additional procedures on a separate piece of paper if necessary.

**FIRST CYCLE BETWEEN SEPTEMBER 1, 2017 AND MAY 31, 2024:**Date of Service (mm/yy/dddd): CPT Code- Check the box(s) that apply (see page 2):

<b>S4035</b>	<input type="checkbox"/>
<b>58321</b>	<input type="checkbox"/>
<b>58322</b>	<input type="checkbox"/>

Provider TIN/PIN: Provider NPI: Provider Name: Provider Address: Provider Phone: Amount Paid

**SECOND CYCLE BETWEEN SEPTEMBER 1, 2017 AND MAY 31, 2024:**

Date of Service (mm/yy/yyyy): _____	
CPT Code- Check the box(s) that apply (see page 2):	
S4035	<input type="checkbox"/>
58321	<input type="checkbox"/>
58322	<input type="checkbox"/>
Provider TIN/PIN: _____	Provider NPI: _____
Provider Name: _____	
Provider Address: _____	
Provider Phone: _____	Amount Paid _____

**THIRD CYCLE BETWEEN SEPTEMBER 1, 2017, AND MAY 31, 2024:**

Date of Service (mm/yy/yyyy): _____	
CPT Code- Check the box(s) that apply (see page 2):	
S4035	<input type="checkbox"/>
58321	<input type="checkbox"/>
58322	<input type="checkbox"/>
Provider TIN/PIN: _____	Provider NPI: _____
Provider Name: _____	
Provider Address: _____	
Provider Phone: _____	Amount Paid _____

*\*Please visit [www.InfertilityInsuranceSettlement.com](http://www.InfertilityInsuranceSettlement.com) for an Appendix to the Claim Form for additional cycle history.*

**STEP 4: DOCUMENTATION**

Provide the required supporting evidence to support the procedure(s) described in **STEP 3**. Examples of acceptable forms for supporting evidence might include a bill from your provider, a medical record or a self-pay agreement. Evidence provided must, at a minimum, confirm (1) that you received a service, (2) what service you received, and (3) that you were billed for that service.

**Questions? Visit [www.InfertilityInsuranceSettlement.com](http://www.InfertilityInsuranceSettlement.com) or Call 1-800-205-6861**

### STEP 5: CERTIFICATION AND SIGNATURE

I certify under penalty of perjury that the information included in this Claim Submission Form and the accompanying supporting evidence are true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

Information on where and how to submit your Claim Submission Form can be found on page 2.